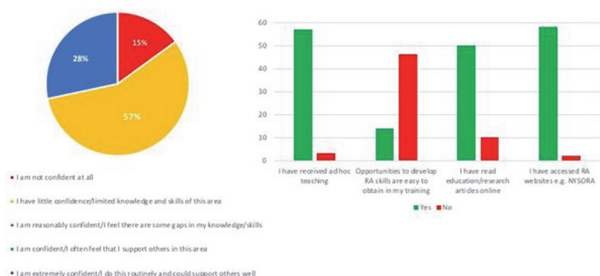


Departmental survey regarding overall trainee confidence in and exposure to RA prior to starting programme

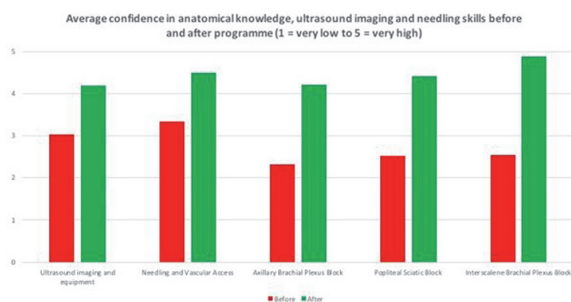


Abstract B167 Figure 1

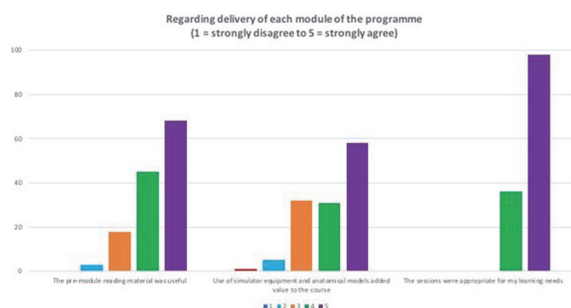
We designed and delivered a modular RA teaching programme, aiming to increase confidence and skill acquisition for anaesthetic trainees.

Methods Sixty trainees enrolled onto our programme over a 16-month period. RA fellows and consultants taught five modules; the first two sessions covered ultrasound imaging, equipment and needling, with the remainder targeting commonly encountered Plan A blocks²(popliteal sciatic, axillary and interscalene brachial plexus blocks). Relevant educational material was emailed prior to each module. Small group teaching was employed, using simulator equipment, anatomical models, and live scanning to ensure that key concepts, especially anatomy, were adequately grasped. Feedback was sought after each module. Due to regular trainee rotation, individuals could resume where they left off upon return to our Trust at a later date.

Results Average confidence across multiple modules (where 1 is low and 5 is high) increased from 2.91 before attending to 4.28 after attending sessions. All trainees either agreed or strongly agreed that the sessions were appropriate for their training needs.



Abstract B167 Figure 2



Abstract B167 Figure 3

Conclusions The regional anaesthesia passport programme has led to a demonstrable improvement in confidence relating to core aspects of RA amongst trainees.

B168 SEVERE ALLERGIC REACTION AFTER GENERAL ANAESTHESIA AND PECS BLOCK

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Background and Aims PECS block is an established regional block for patients undergoing mastectomy(1).

Methods A 38 year-old woman was scheduled for total mastectomy and sentinel lymph node biopsy for breast cancer and was consented for a PECS II block and a general anaesthetic. She was on ramipril and bisoprolol for a decline in LV function following chemotherapy. She reported no known allergies. **Results** Anaesthesia was induced with fentanyl 100mcg, propofol 200mg and rocuronium 30 mg iv for facilitation of endotracheal intubation. Following induction an ultrasound-guided PECS II block was carried out with no complications. Thirty mls of l-bupivacaine were used in total. Shortly after amoxicillin/clavulanic acid was given iv and the surgeon injected blue dye. Five minutes after skin incision the patient's blood pressure dropped to 50/20 mmHg. No rush was noted. 100% oxygen was given. Allergy to the antibiotic or the local anaesthetic was suspected and the patient was treated as such. After a total of 450mcg of adrenaline the patient was stabilized. A decision was made to proceed with the procedure. At the end she was transferred to ICU and extubated the same night. She attended an allergy clinic two weeks later where allergy to the blue dye was diagnosed.

Conclusions Blue dye allergy is a rare but potentially devastating adverse effect of blue dye injection for breast surgery and can present without the typical signs of oedema, urticaria and bronchospasm(2). Even though intra-operative allergic reactions are caused mostly by muscle relaxants (70%), latex(10%) and antibiotics, blue dye should always be considered(2,3).

B169 DEVELOPMENT OF AN INTEGRATED CHEST TRAUMA REFERRAL PATHWAY AND DECISION MAKING AID

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10.1136/rapm-2022-ESRA.244

Background and Aims Patients with rib fractures are at high risk of morbidity and mortality. After initial resuscitation, management is focused on timely administration of multimodal analgesia and supportive therapies to prevent secondary complications.

We aimed to develop a system that can expedite the identification of patients with rib fractures to the Trauma Anaesthesia Group whilst also prompting referring clinicians to recognise high risk patients and institute locally agreed multimodal analgesia protocols.